MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

APPLICATION FOR BENEFITS

Date	Our Policy Holder	Accident Date	File Number

The no-fault law provides benefits for medical expenses, wage loss and replacement services, as well as survivors' loss. To enable us to determine if you are entitled to any of these benefits, please complete this application form and return it promptly.

IMPORTANT -- TO BE ELIGIBLE FOR BENEFITS, YOU MUST:

(1) Complete, sign & return this application no later tham one (1) year from the date of the accident.

(2) Submit bills for expenses promptly, but no later than one (1) year from the date the expense was incurred.

(3) Sign the attached authorization(s).

Applicant's Name	Home Phone	Business Phone

Address (No., Street, City or Town, State, Zip)	Birthdate	Soc. Sec. No.

Date & Time of Accident am pm	Place of Accident (Street, City or Town, State)

Brief Description of Accident:

general

Describe motor vehicles owned by you, your spouse, or relatives of either you or your spouse residing in the same houshold on the day of the accident:

Vehicle	Lic. Plate No.	Owner	Insurer	Policy No.

☐ Check here if there are no vehicles in the household.

Describe the injury which resulted from this accident:

medical

Were you treated by a doctor? Name, Address & Phone of doctor(s) providing treatment.

☐ Yes ☐ No

If treated in a hospital, were you

☐ In-patient ☐ Out-patient ?

Hospital Name and Address

Do you expect to have more medical treatment? ☐ Yes ☐ No ☐ Undetermined

Have you received any benefits under a medical plan or health insurance? ☐ Yes ☐ No

Name of your medical plan, ins. Company, govt. program or HMO

Policy or plan number:

Name

Address

Identification No.

( )

City State Zip

Telephone No.

Have you received any medical treatment for the same or similar symptoms prior to this accident?

☐ Yes ☐ No

If yes, list name, address & phone of physician(s) providing treatment

Were you on the job working when the accident occurred? ☐ Yes ☐ No

Date Disability from Work Began

-Date Returned or Anticipate -Returning to Work

Avg. Weekly Wage/Salary

Have you received any benefits under worker's compensation, social security, or any wage or salary continuation plan?

☐ Yes ☐ No

If yes, indicate source of payment: _____

Amount of payment per month: _____ Per Week: _____

wage loss

Are you currently receiving unemployment benefits? ☐ Yes ☐ No

List names, addresses & phones of present employer(s):

Name, address & phone Occupation Date Hired

Name, address & phone Occupation Date Hired

exp.

As a result of your injury, have you incurred any other expenses, such as transportation costs or expenses for services you would have performed for yourself or your dependents?

☐ Yes ☐ No If yes, explain on a separate sheet and attach

These statements are true and complete to the best of my knowledge:

Date: _____

Signature of applicant or parent or guardian

Do Not Detach

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize a physician, hospital, clinic, or other medical institution to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

_____ Date: _____

signature of applicant or parent or guardian

Do Not Detach

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are required to provide this information in accordance with the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972.

_____ Date: _____

Signature

_____

Social Security Number

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ATTENDING PHYSICIAN'S REPORT

Date	Our Policyholder	Accident Date	File Number

To assist us in determining benefits due under the Michigan Motor Vehicle No Fault Law, the attending physician must complete this report. You are required to provide this information in accordance with the Michigan Motor Vehicle No Fault Law, P.A. 294 of the Public Acts of 1972.

Patient's Name
Street, City, State, Zip Code
Age Occupation/Job Description
History of Occurrence and Injury as Described by Patient
Diagnosis and Concurrent Conditions
When did symptoms first appear? When did patient first consult you for this condition?
Have you treated patient before this date? If yes, when?
Has patient ever had same or similar condition? If yes, state when and describe
Patient was unable to work: If still disabled, patient should be able to return to work on: From: Through: Date:
If patient was hospitalized, name of hospital Period of Hospitalization From: To:
Is patient still under your care for this condition? If yes, indicate projected duration and frequency of treatment:

REPORT OF SERVICES

Attach itemized bills for this accident only, and include amounts paid or payable by other sources. Attach verification of payment or rejection.

IRS/TIN Identification Number

Physician's Name (Please Print)

Address

Physician's Signature

City, State, Zip Code